



**AUTHORIZATION FOR DISCLOSURE OF  
CONFIDENTIAL INFORMATION**

Patient Name: \_\_\_\_\_

Address: \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Social Security #: \_\_\_\_\_

I understand that my records are confidential and cannot be disclosed without my written authorization, except when otherwise permitted by law. Information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer protected. I understand the specified information to be released may include, but is not limited to: history, diagnosis, and/or treatment of drug or alcohol abuse, mental illness/psychological, or communicable disease, including Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS) and I authorize the release of all such records.

I authorize Tyler Neurosurgical Associates to release the protected health information specified above to be

**Released To:**

Person/Facility: \_\_\_\_\_

Address: \_\_\_\_\_

**Information to be released:**

\_\_\_\_\_ Complete record

\_\_\_\_\_ Records of care for the following dates: \_\_\_\_\_ to \_\_\_\_\_

Other (Specify): \_\_\_\_\_

**Purpose of disclosure:**

\_\_\_ Medical Care \_\_\_ Attorney \_\_\_ Insurance \_\_\_ Social Security/Disability

Other(Specify): \_\_\_\_\_

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the Medical Records Department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

A photocopy of this authorization is as valid as the original. This authorization will expire One Hundred Eighty (180) days from the date of my signature unless I revoke the authorization prior to that time or unless otherwise specified by date, event, or condition as follows:

Patient's signature: \_\_\_\_\_

Date: \_\_\_\_\_